Children's Medical Report

Name of Child _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent of Guardian _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No___ Yes___ If yes, what?_____

_____

2. Is child currently under a doctor's care? No___ Yes___ If yes, for what reason?_____

_____

3. Is the child on any continuous medication? No___ Yes___ If yes, what?_____

_____

4. Any previous hospitalizations or operations? No___ Yes___ If yes, when and for what?_____

_____

5. Any history of significant previous diseases or recurrent illness? No___ Yes ___;
   diabetes No ___Yes ___; convulsions No___ Yes ___; heart trouble No___ Yes ___.
   If others, what/when?_____

6. Does the child have any physical disabilities: No___ Yes___ If yes, please describe:_____

_____

Any mental disabilities? No___ Yes___ If yes, please describe:_____

Signature of Parent or Guardian_____**Date**_____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program. Height _____% Weight _____%

Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____

Throat_____ Neck_____ Heart _____Chest _____ Abd/GU_____

Ext _____ Neurological System _____ Skin _____

Results of Tuberculin Test, if given: Type _____ date_____ Normal ___Abnormal _____
Should activities be limited? No___ Yes___ If yes, explain: _____
Any other recommendations: _____

_____ Date of
_____ Examination_____

Signature of authorized examiner/title _____ **Phone #** _____

(Continued on back)

C. Immunization History: The family child care home operator or health official must enter the date immunization was received in the space below or attach a copy of the immunization record.

G.S. 130A-155(b) requires all child care facilities to have this information on file.

Enter date of each dose - Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
*DTP / DT (circle which)					
*Polio					
**Hib					
***Hepatitis B					
*MMR (combined doses)					
OTHER					

* Required by State law.
** Required by State law for children born on or after 10/1/88.
*** Required by State law for children born on or after 7/1/94.